

## **Guiding Principles for Determining Information Exchange Architecture Implementation**

1. We will utilize Markle Foundation's Common Framework for initial guidance in establishing health information exchange technology and policy:
  - a. Technology Principles
    - i. It is preferable to implement a "Thin" network, but flexibility may be necessary to centralize data in the short term
    - ii. Avoid "Rip and Replace"
    - iii. Separate Applications from the Network
    - iv. Decentralization
    - v. Federation
    - vi. Flexibility
    - vii. Privacy and Security
    - viii. Accuracy
  - b. Policy Principles
    - i. Openness and Transparency
    - ii. Purpose Specification and Minimization
    - iii. Collection Limitation
    - iv. Use Limitation
    - v. Individual Participation and Control (does this conflict with desire to limit opt-out ability?)
    - vi. Data Integrity and Quality
    - vii. Security Safeguards and Controls
    - viii. Accountability and Oversight
    - ix. Remedies
2. We will use non-proprietary standards and interoperability specifications established by Health Information Technology Standards Panel, Certification Commission for Health IT or NCVHS Nationwide Health Information Network Functional Specifications, or from recognized standards development organizations (e.g., HL7, OASIS, DICOM) or recognized standards selection organizations (e.g., IHE). We will not develop/promote non-standard or proprietary architectures unless there is no recognized standard to accomplish the intended data exchange.
3. We will encourage regional health information organizations to establish and implement architectures that meet the regional market needs, with the state providing common infrastructure components based on availability of existing state IT assets or ease of implementation.
4. We will work with existing electronic health information data sources, as much as possible, to minimize disruptions to the State's health care industry.
5. We will focus on HIE solutions that accelerate clinical information exchange access and use by healthcare professionals near-term, recognizing and planning for incremental enhancements to both clinical information breadth and depth (adapted from HIMSS-EHR Vendors Association Interoperability Roadmap, <http://www.himssehrva.org>)

- a. Phase 1: Share Care Status Information: Structured medical summaries support transition of care among providers.
  - b. Phase 2: Share Diagnostic Results and Therapeutic Information: Adds patient-created information and emergency summaries plus e-Lab and e-Prescription, with selected coded information.
  - c. Phase 3: Advanced Clinical Support and Access Control: Extends access control, exchange of continuity of care documents and dynamic queries for medications and allergies with extensively coded information.
  - d. Phase 4: Collaborative Care, Active Quality Reporting and Health Surveillance: Introduces workflow-oriented collaborative services and the second generation of public health surveillance and quality reporting.
6. We will identify consumer specific HIE and HIT solutions when they become widely available. We will promote consumer access via HIT tools currently provided by their care-provider, the State, the Federal government or other HIPAA designated entity (e.g., insurance carrier.)
7. We will identify and promote use of appropriate existing state IT assets to increase value of information exchange for both private and public sector healthcare delivery.